UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Tykerb (lapatinib ditosylate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of advanced or metastatic breast cancer whose tumor overexpresses HER2.
- Documentation of prior therapy, including an anthracycline, a taxane, and trastuzumab.
- To be given in combination with capecitabine.

Authorized:

Initial PA is granted for 1 year.

Re-Authorization:

Re-auth for 1 year accomplished by an updated letter of medical necessity.